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Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers

Sean Murphy, Administrator
Protection of Conscience Project

Responding to: Cantor J, Baum K. The Limits of Conscientious Objection - May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception? N Eng J Med 2004 Nov 4;351(19):2008–2012.

Note: The New England Journal of Medicine offered the following explanation for declining to publish this response: "We thought that it was interesting, but that its focus, content, and interest to readers were such that it did not meet our needs."

Abstract

The authors suggestion that patients should be able to access morally controversial services without compromising health care workers' freedom of conscience is most welcome, as is their acknowledgment that "other options exist" when pharmacists decline to fill prescriptions.

However, the conflicting interests of patients and health care providers interests may be accommodated but cannot be balanced because they concern fundamentally different goods. Neither the concept of autonomy nor an appeal to the "needs" of the patient help to resolve conflicts in these situations, while fiduciary obligations cannot necessarily be invoked because they are not governed by fixed rules, and there can be no obligation to participate in wrongdoing.

The fact that post-coital interceptives can cause the death of an early embryo is at the heart of the controversy over the drugs. The authors' advocacy of mandatory referral follows from their belief this is not wrong. Those with different beliefs do not share their conclusions.

Conscientious objection does not prevent patients from obtaining post-coital interceptives from other sources. As the exercise of freedom of speech does not force others to agree with the speaker, the exercise of freedom of conscience does not force others to agree with an objector. Concerns about access to legal services or products can be addressed by dialogue, prudent planning, and the exercise of tolerance, imagination and political will. A proportionate investment in freedom of conscience for health care workers is surely not an unreasonable expectation.

"Courts," write Julie Cantor, J.D. and Ken Baum, M.D., J.D., "have held that religious freedom does not give health care providers an unfettered right to object to anything involving birth control, an embryo, or a fetus."[1]

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This rhetorical flourish is directed at an imaginary claim not made by objectors, nor even considered in the two cases cited by the authors. *Shelton*[2] affirmed the need to appropriately accommodate a nurse who objected to abortion. *Brownfield*[3] was decided against a Catholic hospital on the grounds that the state protection of conscience statute did not nullify a duty to provide information about post-coital interceptives. The authors' unfocussed rhetoric does not yield principles that can be applied to set the limits of conscientious objection in health care.

However, their suggestion that patients should be able to access morally controversial services without compromising health care workers' freedom of conscience is most welcome, even if one finds their notion of compromise deficient. They also deserve credit for acknowledging (as many do not) that "other options exist" when pharmacists decline to fill prescriptions for post-coital interceptives.[4] Drawing from their examples, the rape complainant who was refused the drug by the Texas pharmacist obtained it across the street,[5] while the patient refused service at the drive-through by the New Hampshire pharmacist could have driven to three other pharmacies within two and a half miles. Her second visit to the same pharmacy and complaint to the media seem more consistent with an attempt to coerce the objector than a desperate effort to obtain a medical service.[6]

The authors' acknowledgement that "emergency contraception is not an absolute emergency"[7] is certainly borne out by the statistics produced by the drug's supporters. According to one estimate, 12,000 prescriptions were thought to have prevented about 700 births.[8] Doing the math, one finds that only about 6% of these women might have been pregnant. The finding is similar to expected pregnancy rates following 'unprotected' intercourse in studies by the Population Council and World Health Organisation (6.2% and 7.4% respectively[9]) nor on a website maintained by Princeton University (8%[10]). One might ask whose interests are best served when women are convinced that they must purchase a product that 92-94% of them do not actually need. The fact that the authors nonetheless use the marketing term "emergency contraception" throughout their article testifies to the impact of a masterful corporate advertising strategy.

That strategy includes assertions that post-coital interceptives do not interfere with "an *established* pregnancy" (emphasis added), another phrase adopted by Cantor and Baum.[11] By this the authors imply that the relevant biological marker for ethical reasoning is implantation of the embryo, not fertilization. Thus, they attach little or no moral significance to the fact that the drug can cause the death of an early embryo by "creating an unfavourable environment for implantation."[12] This, rather than some nebulous 'kinship' to abortion, is what lies at the heart of the controversy over the drugs.

As to doubt about whether or not conception has occurred, such doubts must be resolved in accordance with principles of moral reasoning in circumstances of uncertainty, not by reference to "the concept of abortion." Well-established traditions insist that such doubts be resolved before one undertakes acts that may harm or kill an individual, and that, where doubts cannot be resolved, acts must be ordered to preserve life. In brief: do not pull the trigger if unsure whether the target is a moose or another hunter.

The attempt to achieve "a workable and respectful balance" between conflicting interests of patients and health care providers is laudable,[13] but overlooks the nature of the conflict. In cases of conscientious objection, patients have an interest in obtaining a particular product or service, while health care workers have an interest in their ability to live and work according to their conscientious

convictions. With sufficient imagination and political will, one may find a way to accommodate the interests of both. But their interests cannot be balanced, because they are not commensurable; they concern fundamentally different goods.

Further, the exercise of freedom of conscience by a health care worker is an exercise of *personal* autonomy, not *professional* autonomy. Both worker and patient have an equal claim to personal autonomy because both are human persons, so the concept of autonomy does not help to resolve conflicts in these situations. Even an appeal to the "needs" of the patient in purported opposition to the "morality" of the health care worker is not necessarily helpful, since the meaning of the term "need" is predetermined by an underlying anthropology. Reasoning from different beliefs about what man is and what is good for him leads to different notions of right and wrong, and ultimately to different ethical conclusions.[14]

Nor is conscientious objection necessarily overridden by the fiduciary relationship between pharmacist and patient. Fiduciary obligations are shaped by the demands of the situation, not governed by fixed rules, and a pharmacist-patient relationship may be fiduciary in some respects, but not in others.[15] Notably, no one has ever suggested that the fiduciary obligations of parents, spouses, and attorneys require them to help children, spouses, or clients who want to do something wrong; there is a difference between service and servitude.

That word 'wrong' brings us to the main problem, reflected in the authors' observation that some objectors will refer patients for antibiotics but not for post-coital interceptives. There is nothing unusual about this; people of integrity, including the authors, will invariably refuse to facilitate an act they perceive to be wrong. This can be illustrated by re-phrasing (in italics) two of the authors' key statements to produce a dissonant effect:

> (a) In a profession that is bound by fiduciary obligations and strives to respect and care for patients, it is unacceptable *to be concerned about human life.* (replacing "to leave patients to fend for themselves")[16]
>
> (b) As a general rule, pharmacists who cannot or will not dispense a drug have an obligation to meet the needs of their customers by referring them elsewhere. This idea is uncontroversial when it is applied to common medications such as antibiotics and statins; it becomes contentious, but is equally valid, when it is applied to *drugs to be used for torture*. (replacing "emergency contraception")[17]

Probing further, and legal considerations aside, it is highly unlikely that American security officials who have 'personal' objections to physical torture would refer terrorist suspects who won't talk to "less squeamish allies" willing to do the job.[18] And, judging from the outcry over the now deleted reference to 'extraordinary rendition' in the *9/11 Commission Recommendations Implementation Act*,[19] in this refusal they would be supported by many people who believed torture to be wrong, not excluding Cantor and Baum.

The point is not to equate post-coital interceptives with torture, but to change the subject in order to reveal underlying presuppositions. The authors believe that it is not *really* wrong to cause the death of a human embryo, or to be reckless of its life. Their conclusion - that objecting pharmacists must refer for post-coital interceptives - follows from that belief. Only upon that premise is it possible to

argue that referral can be an ethical obligation, yet the authors do not explain why people who do not share their belief should be forced to accept their conclusion.

On the other hand, those who do not share the beliefs of conscientious objectors are not forced to accept either limitations on services or objectors' beliefs. Conscientious objectors do not prevent people from obtaining post-coital interceptives from other sources, nor does conscientious objection prevent them from being advertised and widely distributed or sold. And the exercise of freedom of conscience no more requires acquiescence in an objector's convictions than the exercise of freedom of speech forces others to agree with the personal convictions of a speaker.

Objectors act primarily to preserve their own moral integrity, not to "block access" to services or to punish or control patients. Their main concern is to avoid being implicated in an immoral act. Hence, the suggestion that an objector might refuse a prescription for HIV drugs is as misplaced as the idea that a physician might refuse to treat someone wounded while committing a robbery. In neither case does treatment implicate the provider in the prior conduct of the patient.

While Cantor and Baum acknowledge that objectors want to separate themselves from morally controversial acts, they seem unduly concerned that objectors, whatever their intentions, will "obstruct patients' access" to legal services or products. Their solution is to suppress freedom of conscience in health care by compelling health care workers to provide or facilitate services that they find morally abhorrent. This does not strike the respectful balance they are seeking, and it ignores three different solutions that, ironically, are suggested by their article.

The first is to persuade objectors that their moral reasoning is defective and convince them to adopt what the authors consider to be superior ethical norms. Respectful dialogue of this kind provides the opportunity to clear up any "medical misunderstandings" and is fully consistent with freedom of conscience and religion as well as democratic ideals. The second is to insist that objectors give reasonable notice of their position to employers and consumers, a practice likely to prevent conflicts that might otherwise occur. The third is to have non-objecting health care workers and others develop and advertise a range of other options for patients, a number of which were suggested by the authors: information on web sites, public education, identification of locations or organizations where services can be obtained, 1-800 numbers, etc.

The solutions the authors quite properly seek are not to be found in a form of repression that is uncharacteristic of the best traditions of liberal democracy, but in dialogue, prudent planning, and the exercise of tolerance, imagination and political will. The solutions have costs, to be sure, but in a country where 10 billion dollars is spent annually on hard core pornography,[20] a proportionate investment in freedom of conscience for health care workers is surely not an unreasonable expectation.

Notes

1. Julie Cantor & Ken Baum, "The Limits of Conscientious Objection - May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?" (2004) 351:19, N Eng J Med 2008 [*Cantor & Baum*] online: <https://www.nejm.org/doi/full/10.1056/nejmsb042263> at 2009–2010.

2. *Shelton v. Univ. of Medicine & Dentistry*, 223 F.3d 220 (3dCir. 2000), online: <https://casetext.com/case/shelton-v-university-of-medicine>.

3. *Brownfield v. Daniel Freeman Marina Hospital*, 208 Cal. App. 3d 405 (Cal. Ct. App. 1989), online: <https://law.justia.com/cases/california/court-of-appeal/3d/208/405.html>.

4. *Cantor & Baum*, *supra* note 1 at 2011.

5. J Baugh, "Pharmacy draws protest: Demonstrators speak out against refusal to fill 'morning-after' pill prescription" *Denton Record Chronicle* (3 February 3, 2004), formerly online:<http://www.kvue.com/news/state/stories/020304kvueprotest-jw.7c050c55.html> .

6. Victoria Guay & Bethany Gordon, "Free to choose? Pharmacists refuse to dispense some drugs on moral grounds", *Foster's Sunday Citizen* (26 September, 2004), formerly online: <http://www.fosters.com/September2004/09.26.04/news/cit_0926b.asp>. An internet query in November, 2004 disclosed two Brooks Pharmacies,within 2.3 miles of Laconia (Flower Medical Center Pharmacy and CVS Pharmacy), and three more pharmacies within six miles.

7. *Cantor & Baum*, *supra* note 1 at 2011.

8. Janet Cooper, Brenda Osmond & Melanie Rantucci, "Emergency Contraceptive Pills-Questions and Answers"(2000) 133:5 Can Pharmaceutical J 28.

9. Cited in James Trussell et al, "Estimating the effectiveness of emergency contraceptive pills" (2003) 67:4 Contraception 259 at 261 n 20, 262 n 11, online: <https://www.contraceptionjournal.org/article/S0010-7824(02)00535-8/fulltext>.

10. NOT-2-LATE.com - The Emergency Contraception Website, "How effective is emergency contraception?" *Internet Archive Wayback Machine* (website), online: <https://web.archive.org/web/20041107021234/http://ec.princeton.edu/questions/eceffect.html>.

11. *Cantor & Baum*, *supra* note 1 at 2009

12. *Ibid*.

13. *Cantor & Baum*, *supra* note 1 at 2010.

14. Sean Murphy, "Freedom of Conscience and the Needs of the Patient." (Paper delivered at the Obstetrics and Gynaecology Conference New Developments - New Boundaries in Banff, Alberta, 11 November, 2001)[unpublished], online:<https://www.consciencelaws.org/publications/presentations/presentations-001-needs.aspx>

15. *McInerney v. MacDonald*, [1992] 2 SCR 138 at 149, online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/884/1/document.do>

16. *Cantor & Baum*, *supra* note 1 at 2011.

17. *Ibid*.

18. Jonathon Alter, "Time to Think About Torture", *Newsweek* (5 November, 2001) 45, online: <https://www.newsweek.com/time-think-about-torture-149445>.

19. US Bill HR 4674, *To prohibit the return of persons by the United States, for purposes of detention, interrogation, or trial, to countries engaging in torture or other inhuman treatment of persons*, 108th Cong, 2003-2004, online:<https://www.congress.gov/bill/108th-congress/house-bill/4674>.

20. "Porn In The U.S.A.", CBS News (5 September 2004) online: <https://web.archive.org/web/20041111095316/http://www.cbsnews.com/stories/2003/11/21/60minutes/main585049.shtml>.